REVITALIZE
INFUSION CENTER

Ocrevus®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis (please complete to indicate the correct diagnosis):

☐ Multiple Sclerosis_____ ICD-10 Code: G35.____

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Required Information:
  - Hepatitis B virus screening
  - Quantitative serum immunoglobulin screening (including IgM, IgA, IgG)

Height: _____

Weight: _____

Ocrevus (ocrelizumab) Orders:

☐ **Loading Dose:** Administer 300 mg IV on week 0 and week 2 to provide 2 total doses

☐ **Maintenance Dose:** Administer 600 mg IV once every 6 months for 12 months

Pre-Medication Orders: 30 minutes prior to infusion

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg PO

☐ Methylprednisolone 125 mg IV ☐ Other: _____

Lab Orders:

☐ CBC with Diff, CMP every 6 months ☐ IgG and Vitamin D every 12 months

☐ Other: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus